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104TH CONGRESS
1ST SESSION

H. R. 381

To improve health status in medically disadvantaged communities through comprehensive community-based managed care programs.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 4, 1995

Mr. TOWNS introduced the following bill; which was referred to the Committee on Commerce

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A BILL

To improve health status in medically disadvantaged communities through comprehensive community-based managed care programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Comprehensive Health Access District Act''.

SEC. 2. DEFINITIONS.

(a) COMPREHENSIVE HEALTH ACCESS DISTRICT.—The term ''comprehensive health access district'' means a community in which unemployment and the percentage of resident with incomes below the poverty line are greater

than the national average, and in which a majority of the following conditions occur at rates greater than the national average:

(1) Infant mortality and low birth-weight babies.

(2) Proportion of children below the age of 5 who have not received age-appropriate routine childhood immunizations.

(3) Hospitalization for preventable illnesses and conditions that may be managed successfully on an outpatient basis, such as otitis media, diabetes, and hypertension.

(4) Emergency room visits for nonemergency conditions.

(5) Accidental injury.

(6) Incidence of tuberculosis, acquired immune deficiency syndrome, Black Lung disease, or cancer.

(7) Incidence of violent crimes.

(b) COMPREHENSIVE COMMUNITY-BASED HEALTH ACCESS PLAN.—The term ''comprehensive community-based health access plan'' (hereafter in this Act referred to as a ''health access plan'') means an entity that provides health care services on a prepaid, capitated basis or any other risk basis and that the Secretary has certified meets the requirements contained in section 5 of this Act.

(c) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 3. MEDICAID STATE PLAN REQUIREMENTS FOR COMPREHENSIVE HEALTH ACCESS DISTRICTS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by adding after paragraph (62) the following new paragraph:

''(63) provide that each comprehensive health access district located within the State is served by a comprehensive community-based health access district plan.''

SEC. 4. HEALTH ALLIANCE OBLIGATIONS WITH RESPECT TO COMPREHENSIVE HEALTH ACCESS DISTRICTS.

Each Health Alliance or other health insurance purchasing cooperative created as a result of the enactment of comprehensive health care reform legislation that receives premiums on behalf of persons formerly insured under title XIX of the Social Security Act and whose boundaries encompass a comprehensive health access district shall insure that at least one comprehensive community-based health access plan is available to persons living in such district.

SEC. 5. COMPREHENSIVE COMMUNITY-BASED HEALTH ACCESS PLANS.

To be certified as a comprehensive community-based health access plan, an entity must meet all of the following requirements:

(a) ORGANIZATIONAL REQUIREMENTS.—A health access plan must—

(1) be a public or private organization, organized under the laws of any State;

(2) locate its primary place of business in the comprehensive health access district it serves;

(3) give preference in hiring to otherwise qualified individuals who live within the comprehensive health access district; and

(4) have made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals enrolled in the plan are in no case liable for debts of the plan in case of the plan's insolvency. Provisions against the risk of insolvency may include—

(A) escrow or similar arrangements to ensure that funds for the payment of providers are available only for such payments and cannot be otherwise used by the plan;

(B) reinsurance purchased by the plan of an amount which is reasonably adequate to insure against unexpected costs;

(C) a demonstration of financial viability, as evidenced by the plan's obtaining a significant amount of reinsurance, line of credit, or performance bond; or

(D) such other mechanisms and requirements as the State finds appropriate.

(b) SERVICE REQUIREMENTS.

(1) BASIC BENEFITS.—A health access plan shall provide, either directly or through arrangements with providers, the following basic benefits:

(A) Hospital services, including inpatient, outpatient and 24-hour emergency services.

(B) Emergency and ambulatory medical and surgical services.

(C) Physicians' services.

(D) Medical care other than physicians' services recognized under State law and furnished by licensed practitioners within the scope of their practice as defined by State law.

(E) Dental services.

(F) Vision services.

(G) Preventive health care services (including children's eye and ear examinations to determine the need for vision and hearing correction, well child services, immunizations against vaccine-preventable diseases, and screening for elevated blood lead levels).

(H) Outpatient laboratory, radiology, and diagnostic services.

(I) Ambulance services.

(J) Mental health and substance abuse services.

(K) Family planning services and services for pregnant women.

(L) Outpatient prescription drugs and biologicals.

(2) COMMUNITY-BASED HEALTH SERVICES.—In addition to providing the services described in paragraph (b)(1), a health access plan shall—

(A) identify the most frequent causes of morbidity and mortality in the comprehensive health access district (such as acquired immune deficiency syndrome, tuberculosis, mental illness, substance abuse and addiction, childhood developmental disorders (particularly those caused by children's exposure to violence), asth-

ma, teen pregnancy, unhealthy behaviors (such as smoking and high-fat diets), and lead poisoning); and

(B) design and implement programs of prevention, early intervention, or treatment intended to ameliorate or eliminate the factors identified in subparagraph (b)(2)(A).

(3) COORDINATION OF SERVICES.—In addition to providing the services described in paragraphs (b)(1) and (b)(2), a health access plan must promote its enrollees' access to social, educational or economic services (such as child day care, nutritional services, vocational training, and adult literacy programs).

(c) SERVICE NETWORK REQUIREMENTS.—

(1) BASIC SERVICE NETWORK.—A health access plan shall enter into arrangements with a sufficient number and variety of providers to guarantee that—

(A) the plan's enrollees have access to the services described in subsection 4(b); and

(B) the provider network takes into account and is representative of the cultural identity and diversity of the community being served.

(2) TRADITIONAL COMMUNITY PROVIDERS.—A health access plan shall, to the extent feasible, draw upon health care providers currently serving the community, including community health centers (as defined in section 330(a) of the Public Health Service Act) and hospitals operated by units of local government, in developing its service network.

(3) DEVELOPMENT OF NEW HEALTH RESOURCES.—A health access plan shall develop new health resources in the community (such as school-based clinics, mobile screening programs, and clinics based in public housing) to meet needs that are not met by existing community resources.

(d) ACCESS STANDARDS.—A health access plan shall insure that each individual enrolled in it—

(1) is linked with the primary care physician within the health access plan's provider network of the individual's choice and has access to that doctor on a 24-hour a day, 7-day a week basis;

(2) has round-the-clock telephone access to a central program office for information purposes as well as to voice grievances; and

(3) has access to interpreter services as necessary (where a significant proportion of the population in the community health access district is non-

English speaking, the health access plan shall insure that a corresponding proportion of its health care providers have a multilingual capability).

(e) QUALITY ASSURANCE STANDARDS.—A health access plan shall establish and maintain a quality assurance program that includes at least the following activities:

(1) TREATMENT STANDARDS.—A health access plan shall establish—

(A) minimum standards for treating patients that participating providers must satisfy;

(B) a program of ongoing medical record reviews and other provider audits to insure compliance with the plan's treatment standards; and

(C) a system of sanctions to insure that providers who do not comply with the plan's treatment standards will be penalized and, if found to be repeatedly out of compliance, terminated from participation in the health access plan service network.

(2) DATA COLLECTION.—A health access plan shall monitor morbidity and mortality within the comprehensive health access district and identify the leading causes of death and disease.

(3) MEMBER SURVEYS.—A health access plan shall survey its enrollees on a regular basis to determine their satisfaction with the quality of services received.

(4) INDEPENDENT QUALITY AUDITS.—A health access plan shall be evaluated on a regular basis by an independent health care accrediting organization.

(f) EFFECTIVE GRIEVANCE PROCEDURES.—A health access plan must provide for effective procedures for hearing and resolving grievances between the plan and individuals enrolled in the plan.

(g) CONFIDENTIALITY OF ENROLLEE RECORDS.—

(1) A health access plan shall ensure that information concerning its enrollees is protected from unauthorized disclosure by the plan, its employees or its providers.

(2) To promote the coordination of benefits to health plan enrollees, a health access plan may disclose information about its enrollees to the extent necessary to facilitate the enrollee's receipt of services and assistance from other entities.

SEC. 6. DESIGNATION OF COMPREHENSIVE HEALTH ACCESS DISTRICTS AND CERTIFICATION OF COMPREHENSIVE COMMUNITY-BASED HEALTH ACCESS PLANS.

The Secretary shall designate a community that meets the criteria set forth in section 2(a) of this Act a comprehensive health access district and shall certify an entity that meets the criteria set forth in section 5 of this Act as a comprehensive health access plan. Each such certification and designation shall be reviewed every five years. The Secretary may delegate all or part of the certification function to the State in which the health access plan operates.

SEC. 7. NATIONAL HEALTH OUTCOMES RESEARCH AND EVALUATION.

(a) PROVISION OF INFORMATION.—In order to evaluate the performance of health access plans in improving the health status of persons living in comprehensive health access districts, each health access plan shall provide the Secretary, at a time and in a manner specified by the Secretary, at least the following information:

(1) Information on the characteristics of enrollees that may affect their need for or use of health services.

(2) Information on the types of treatments and services and outcomes of treatments with respect to

the clinical health, functional status and well-being of enrollees.

(3) Information on enrollee satisfaction.

(4) Information on health care expenditures, volume and prices of procedures, and use of specialized services.

(b) ANALYSIS OF INFORMATION.—The Secretary shall analyze the information reported by health access plans in order to report to Congress, the plans and the public, no less than annually, on the following:

(1) The health status of persons living in comprehensive health access districts (particularly those indicators listed in section 2(a) of this Act).

(2) The level and rate of expenditures by health access plans on medical services and other programs to improve health status.

(3) The effectiveness of health access plans in improving health outcomes (particularly outcomes related to health indicators listed in section 2(a) of this Act).

(c) RESEARCH.—

(1) The Secretary shall examine the relationship between socioeconomic factors and health status and, based on his findings, suggest interventions appropriate to comprehensive health access districts.

(2) The Secretary may contract with non-governmental entities to perform this research. Persons undertaking this work shall have access to the information provided by the health access plans to the Secretary.

SEC. 8. CHANGES TO THE MEDICAID STATUTE TO FACILITATE STATE CONTRACTS WITH COMPREHENSIVE COMMUNITY-BASED HEALTH ACCESS PLANS.

(a) Section 1903(m)(2) of the Social Security Act (42 U.S.C. 1396b(m)(2)) is amended by adding after subparagraph (H) the following new subparagraph:

''(I) Clause (ii) of subparagraph (A) does not apply to any entity certified as a comprehensive health access plan pursuant to section 6 of the Comprehensive Health Access District Act.''

(b) This amendment shall apply to payments for medical assistance for calendar quarters beginning on or after July 1, 1996.

SEC. 9. REGULATIONS AND EFFECTIVE DATE.

(a) The Secretary shall promulgate regulations necessary to implement this Act.

(b) This Act shall take effect on July 1, 1996, without regard to whether or not final regulations to carry out this Act have been promulgated by such date.

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